

FILED NOV 16 1945

State File No. \_\_\_\_\_

Registration District No. 20

Primary Registration District No. 5450

Registrar's No. 88

1. PLACE OF DEATH:

(a) County Generty  
 (b) City or town North Township  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 1  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
 In this community Lifetime years, months or days

3. (a) PRINT FULL NAME

Frederick Sumner

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex M. D. 5. Color or race W. 6. (a) Single, widowed, married, divorced Widowed  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased: April 5 1865  
 (Month) (Day) (Year)

8. AGE: Years 80 Months 6 Days 6 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Generty Co Mo D  
 (City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Frederick Sumner  
 13. Birthplace Madison Miss  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Deligh Long  
 15. Birthplace \_\_\_\_\_  
 (City, town, or county) (State or foreign country)

16. (a) Informant Ann Lee Walker

(b) Address Albany Mo

17. (a) Burial (b) Date thereof Oct 13-45  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old Brick

18. (a) Signature of funeral director to be signed

(b) Address Albany Mo

19. Oct 15-1945 (Date received local registrar) (b) James H. Dekater (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Generty 30  
 (c) City or town Albany  
 (If outside city or town limits, write "RURAL") 0  
 (d) Street No. \_\_\_\_\_ (If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 11  
 year 1945 hour 9:15 minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from Jan 1944, to Oct 11 1945  
 that I last saw him alive on Oct 11 1945  
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Arterio sclerosis  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy 938

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature James H. Dekater (M. D. or other) Do  
 Address Albany Mo Date signed 10/12/45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed Leifur Brooker  
Licensed Embalmer No. 3329  
P. O. Address Albany, Mo.

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

If this body is not embalmed, fact should be so stated above.

STATE OF MISSOURI  
DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Dec  
Registrar's No. 88

Registration District No. 120 Primary Registration District No. 15450

1. PLACE OF DEATH:  
(a) County Hartley  
(b) City or town Rural - Miller township  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Hartley  
(c) City or town Altamont, Mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Frederick Summa  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (include pregnancy within 3 months of death)

8. AGE: Years 80 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) MO  
10. Usual occupation Farmer  
11. Industry or business Farm

PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

MOTHER FATHER {  
12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_  
17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)  
(c) Place: burial or cremation \_\_\_\_\_  
18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. Nov 26-1945 (b) Harold T. DePeters  
(Date received local registrar) (Registrar's signature)

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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